Overview

The Office of the Health Insurance Commissioner (OHIC) of the State of Rhode Island has a comprehensive and innovative rate review process established for all lines of commercial insurance. OHIC was awarded $1 million in rate review grant funds in September 2010 to: (1) expand the scope of current rate review and approval activities; (2) enhance the rate review process through staffing; and (3) improve consumer protection standards and communication in the rate review process. To date, OHIC has made significant progress on the Cycle I activities as documented in our quarterly reports to HHS. We propose to use federal funds available to states through Cycle II of the U.S. Department of Health and Human Services' (HHS) Health Insurance Rate Review Grant program to build on our work in Cycle I and accomplish two goals: (1) institutionalize the rate review program; and (2) engage health plans in delivery system transformation through implementation of OHIC's Affordability Standards. These goals align with HHS' objectives for Cycle II funding:

> (1) *enhance a meaningful and comprehensive effective rate review program that is transparent to the public, enrollees, policyholders, and to the Secretary, and under which rate filings are thoroughly evaluated and, to the extent permitted by applicable State law, approved or disapproved; and*
>
> (2) *develop an infrastructure to collect, analyze, and report to the Secretary critical information about rate review decisions and trends, including, to the extent permitted by applicable State law, the approval and disapproval process of proposed rate increases.*

OHIC will meet HHS' grant objectives and OHIC's stated goals through completion of the activities proposed in this application. We will improve the effectiveness of health insurance rate regulation in Rhode Island, and anticipate that our work will provide valuable lessons for other states engaged in this process.

A. Current Health Insurance Rate Review Capacity and Processes

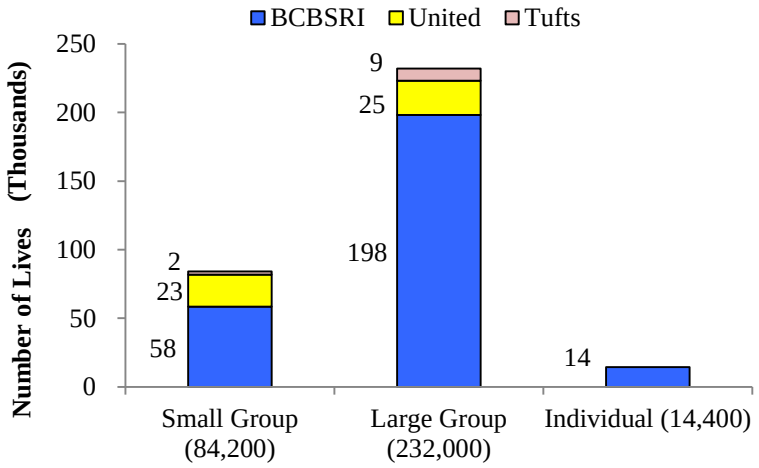
Health Insurance Markets and Regulatory Structure in Rhode Island

As of December 2010, there were approximately 555,000 lives covered in the Rhode Island commercial health insurance market.[1] There are three major health insurers in this market for individuals under 65 years of age: Blue Cross Blue Shield of Rhode Island (BCBSRI), United Healthcare of New England (United), and Tufts Health Plan (Tufts). OHIC has jurisdiction over Rhode Island's fully insured commercial health insurance market, which includes individual (direct pay), small, and large group. Forty percent of the total commercial market (224,000 lives) is covered through self-funded groups that are exempt from state-based regulation, and consequently exempt from rate review by the state. Within Rhode Island, BCBSRI, United, and Tufts comprise 82%, 15%, and 3% of the fully-insured market share respectively. All three insurers sell products in both the small and large group markets. The number of lives covered in each market (individual, small group, and large group) is shown in Figure 1. Approximately 84,000 lives are covered in the small group market and 232,000 lives in the large group market, accounting for roughly 15% and 42% of the commercial health insurance market respectively.

[1]Analysis of Rhode Island Commercial Insurance Enrollment Trends by Line of Business and Carrier as of December 2010: http://www.ohic.ri.gov/documents/Insurers/Reports/2010%20RI%20Commercial%20Ins%20Enrollment/RI%20Commercial%20Insurance%20Enrollment%20Trends.pdf

BCBSRI is the only carrier that sells products in the individual market, covering roughly 14,000 lives. Additionally, OHIC is responsible for regulating Medicare supplemental ("Medigap") insurance, which covers approximately 32,000 lives in Rhode Island. The Department of Business Regulation (DBR), OHIC's sister agency, regulates other accident and sickness policies (limited benefit, limited duration, disease-specific coverage) under a separate set of statutes.

Figure 1: Number of Lives in Rhode Island's Fully-Insured Market by Market Type and Carrier



Prior to OHIC's conception in 2004, DBR reviewed and proposed health insurance premium rate factors annually for both the small and large group market.[2] Instead of reviewing the aggregated dollar value of proposed rates, DBR reviewed on an irregular basis the rate factors that health insurers proposed to use in their separately approved rate manuals for calculating their premium quotes. These variables were projected administrative costs, contributions to reserves, and projected medical inflation.[3] In 2004, when OHIC was established, regulatory standards governing health insurer conduct were substantially broadened in statute.[4] In addition to actuarial soundness, financial solvency, and consumer protection, statutory authority required OHIC to also consider fair treatment of providers as well as whether insurers were working towards the overall affordability, quality, and accessibility of coverage during the rate review process.[5] Two years later, in 2006, OHIC established an annual rate factor review process for all carriers in both the small and large group markets. The goal of rate factor review was to have a transparent, process that allowed for greater public accountability for the rates proposed by health plans. In making its determinations in these decisions, OHIC applied its new statutory criteria.

OHIC, in conjunction with the Health Insurance Advisory Council (HIAC)[6], developed the Affordability Standards in 2009 to establish measurable standards for insurers to meet regarding the requirement that they implement policies that promote system-wide "affordability" of coverage. The Affordability Standards require insurers to: (1) increase each insurer's proportion of medical expenses on primary care by one percentage point per year from 2010 –

[2] Rhode Island General Law 42-62-13, 27-19-6, and 27-20-6
[3] Rhode Island General Law 42-62-13, 27-19-6, and 27-20-6
[4] Rhode Island General Law 42-14.5-1
[5] Rhode Island General Laws 42-62-13, 27-19-6, and 27-20-6
[6] The HIAC is a statutorily mandated advisory group to OHIC, comprised of businesses, providers, and consumers.

2014, (2) support expanding the medical home initiative in Rhode Island, (3) fund the adoption and maintenance of electronic medical records as a percentage of market share, and (4) participate in an on-going dialogue about comprehensive state-wide provider payment reform[7]. These standards were designed to be measurably applied to insurers within the rate factor review process.

The fourth affordability standard was refined to require that insurers include specific hospital contracting requirements as a condition of OHIC's rate factor decision in 2010. This cost-effective contracting with hospitals required that insurers' contracts include provisions to: (1) utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payments to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service; (2) limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index; (3) provide the opportunity for hospitals to increase their total revenue for commercially insured enrollments under contract by at least two additional percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality, or efficiency-based measures; (4) define the parties' mutual obligations for greater administrative efficiencies; (5) promote and measure improved clinical communications between the hospital and each patient or member's designated primary care physician, specialist physicians, long term care facility, or other providers; (6) explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement; and (7) include such other terms as the Commissioner determines, after notice, and an opportunity to be heard, will enhance the cost-effective utilization of appropriate services.[8]

In 2011, OHIC proposed to codify the affordability standards and hospital contracting conditions in regulation by refining the stated powers and duties of the OHIC. Amendments were made to regulation allowing the Commissioner to consider health insurers' compliance with the affordability standards and hospital conditions in rate review.[9] Additionally, OHIC provided the health insurers with guidance on defining which investments fit under the definition of primary care for the purposes of meeting the affordability standards. These investments included money spent by insurers: (1) in payment to primary care physicians and practices; (2) for services provided by a third party integrated into the primary setting – to either patients or the practice itself; (3) in support of multi-payer collaboration for primary care; (4) to promote early and

[7] OHIC Issue Brief, May 19, 2009. Available at:
http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/6_Issue%20Brief.pdf
[8] Final Proposed Regulation 2. Available at:
http://www.ohic.ri.gov/documents/Insurers/Regulations/Amended%20Regulation%202%20/4_%20Final%20Proposed%20Regulation%202.pdf
[9]Concise Explanatory Statement of OHIC Regulation 2. Available at:
http://www.ohic.ri.gov/documents/Insurers/Regulations/Amended%20Regulation%202%20/2_Concise%20Summary%20of%20Proposed%20Regulation%202.pdf

comprehensive access to high quality primary care for children; and (5) to build primary care workforce capacity.[10]

OHIC's Rate Review Process-Components

OHIC's rate review process varies by product type. There are three distinct processes – one for Medigap products, one for individual market products, and one for small and large group rate factors. In the Medigap market, OHIC reviews rates by product as a carrier chooses to revise them. OHIC may approve these rates, suggest modifications for resubmission or initiate an administrative hearing.

BCBSRI is the only carrier in the individual market and offers five products to consumers. An annual rate hearing process is required by statute.[11] Rate factor review for the individual market does not go through the same process as the small and large group market; rather, all individual filings automatically go to hearing pursuant to statute, as described in "Step 4" below.

The process for small and large group rate factor review is unique to Rhode Island. OHIC can approve, reject or modify the inflation factors that insurers use to calculate the rates paid by consumers (as opposed to reviewing actual product rates). Once these rate components are determined, insurers use rating formulas to calculate an employer-specific year long, fixed rate based on that employer's benefit plan and demographic mix. Past claims experience is also considered in the large group market. For small group, rates are calculated using adjusted community rating, with statutorily-allowed variations for age, gender, and family composition within a 4:1 rating band.[12] There are no equivalent statutory or regulatory requirements for large group rating rules; however, OHIC separately reviews insurers' rating formulas and procedures to ensure they are fair and are consistently applied.

The Rhode Island rate review process addresses rate factors, not product-specific rates, to encourage the health insurers and other stakeholders to focus on systemic costs and cost drivers. An exclusive focus on product costs and cost increases brings attention to the actuarial value of benefit design, not the effects of price and utilization changes on premiums, which – along with health plan administrative costs and profits - are what truly drive health insurance costs. This systemic focus allows for a systemic set of policy directions.

The rate factor review process for small and large group rates occurs in four steps during the spring of the year prior to applying the rate factors (i.e. OHIC reviews rate factors for 2012 during the spring of 2011). The process is usually completed over the course of 45-60 days. These four steps are: (1) preliminary internal review, (2) public comment, (3) internal actuarial and substantive review, and (4) rate factor proposal to carriers.

Preliminary Internal Review: Health insurance carriers file their proposed rate factors utilizing the National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filing (SERFF). The carriers use a standard form (Attachment 1) to report their projected annual rate of price and utilization increases for the following categories:

[10] Guidance on Primary Spend for Health Insurers, March 2011. Available at: http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/2011%20Public%20comment%20primary%20care%20spend/1_PRIMARY%20SPENDING%20GUIDANCE%20Final.pdf

[11] Rhode Island General Laws 27-19-6 and 27-20-6

[12] Rhode Island General Law 27-50-5 and OHIC Regulation 11

hospital inpatient, hospital outpatient, pharmacy, primary care, and all other medical, as well as the projected portion of premium for administrative costs and reserves or profits. These trends are also reported as the resulting overall average increase in commercial health insurance premiums. The Executive Counsel and consulting actuary review the proposed trend factors for completeness. They may ask for any clarifications from the health plans at this stage.

Public Comment: OHIC posts all proposed rate factors for oral and written public comment.[13] Public comments are usually collected for four weeks. The rate factors are also presented to HIAC for analysis and comment. A publicly accessible rate review process assists OHIC in holding insurers accountable for goals that may conflict, including financial solvency, consumer protections, fair treatment of providers, and implementing policies that improve affordability, quality, and accessibility of the health care system. At OHIC's discretion, rate factors may also be publicly discussed through public meetings and/or formal hearings.

Internal Review: The Health Insurance Commissioner, Executive Counsel, and consulting actuary work together to assess the actuarial soundness of proposed rate factors and their relationship to each carrier's solvency. The Superintendent of Insurance and the Chief Financial Examiner at DBR participate in this internal review as needed. In addition to financial solvency, OHIC considers the general conduct of insurers when reviewing proposed rate factors. Components considered as part of general conduct are summarized in OHIC's "Standards for Rate Factor Review – Health Plan Evaluation" (Attachment 2). This year, OHIC conducted seven analyses for the submitted 2012 rate factors:

Cost Driver Analysis: This examination assessed the total premium increase requested by each health plan for 2012 and broke down the premium increase into eight categories: (1) adjustment to prior year, (2) hospital inpatient, (3) hospital outpatient, (4) pharmacy, (5) primary care, (6) med/surgery (except primary care), (7) administrative expenses and taxes, and (8) profit and reserves.

Analysis of RI Commercial Insurance Administrative Expense Trends 2005-2010: This report evaluated the rise in administrative expenses for the fully insured plans in recent years and proposed several explanations for the changes in administrative expenses.

New England Group Health Plan Benchmarking: This analysis aimed to develop regional benchmarks of health care cost metrics and to compare those metrics across New England states (Massachusetts, Connecticut, and Rhode Island). The metrics included: (1) surplus as percent of revenue, (2) medical loss ratio, (3) profit as percent of revenue, (4) administrative cost ratios, (5) administrative costs per member per month, (6) filed trend rates by service category, and (7) projected administrative ratios.

Health System Improvements Survey: This assessment summarized health plans' itemized and quantified contributions of finances and other material assets to efforts to improve RI's health care system.

[13] Rhode Island General Laws that govern public disclosure and access to rate filing information include per the Access to Public Record Act (RIGL 38-1-1-et seq.), 27-19-6, 27-20-6, 42-62-13. AG opinion PR 09-01 (http://www.riag.state.ri.us/civilcriminal/show.php?id=568) also applies.

Standards for Rate Factor Review - Health Plan Evaluation: This evaluation attempted to determine whether the health plans' proposed rates or rating formulas were "consistent with the proper conduct of [the insurer's] business and with the interest of the public" as based on RI General Laws: 42-14.5-2 and in Regulation 2.

Provider Contracting Survey Summary: This study analyzed the course and nature of provider payment reform in Rhode Island by examining three areas of hospital contracting: (1) hospital inpatient, (2) hospital outpatient, and (3) professional services.

Analysis of Past Performance Relative to Requested and Approved Rate Factors: OHIC assessed actual past performance and compared requested and approved rate factors for the following measures: (1) percentage of premium contributed to reserves, (2) administrative expense per member per month, and (3) medical loss ratio.

Propose Approved, Modified, or Rejected Rate Factors to Carriers: Upon completion of the internal review, the Health Insurance Commissioner accepts, modifies, or rejects the rate factors requested by the health insurers. OHIC sends a decision letter to each plan and allows health insurers to respond. Insurers can either re-file their rates in accordance with the proposed modifications or OHIC will call a hearing on the original filing. All rates are filed prospectively. OHIC has the authority to perform a comprehensive retrospective analysis to reconcile prior year's proposed versus approved rates; Cycle I funds provided OHIC resources to exercise this authority for the first time in 2011. Market conduct examinations are generally conducted only if there is evidence or suspicion that insurers are not appropriately applying their approved rate factors to calculate premiums.

If an insurer does not re-file their rates in accordance with OHIC's proposed modifications, a full hearing is conducted in compliance with the state Administrative Procedure Act. The insurer(s) and attorney general (the attorney general is statutorily charged with representing the public at a rate hearing) testify before a hearing officer regarding the proposed filing. The hearing officer makes a recommendation to OHIC, and the Commissioner issues a final decision. As described above, when rate factors are filed for the individual market by BCBSRI, the rate review occurs directly through a hearing without first going through initial review, a public comment period, and internal review. Due to the statutorily mandated process required for rate hearings, individual market rate hearings usually require two months to complete. All significant final rate review decisions are posted in plain language on the OHIC web site and communicated in press releases.

Update on Cycle I Grant Funds

OHIC proposed to use funds from the Cycle I grant to improve its comprehensive rate review by focusing on improved analytics and consumer engagement, as well as enhanced oversight of health insurer efforts to reduce underlying cost drivers. More specifically, these grant funds were used to: (1) expand the scope of current review and approval activities, (2) enhance staffing, and (3) improve consumer protection standards and communications.

Expand the scope of current review and approval activities:

- The Cycle I funds have been used to monitor health insurers' compliance with the affordability standards and analyze underlying cost drivers. More specifically,

OHIC collected the primary care spend reporting templates from each of the health plans and published the "Guidance on Primary Spend" report.

- Additionally, OHIC conducted several analyses of carrier-submitted information for the annual small and large group rate factor review (described above in the *Internal Review* section).
- A vendor was selected for the hospital utilization evaluation, which will compare hospital discharge data for measures over time. The vendor is currently working on defining methodology for cost and utilization measures, and will complete an initial evaluation during Cycle I period.
- In coordination with the Rhode Island Department of Human Services, a vendor was identified and a contract was executed for the hospital payment evaluation. The payment evaluation will assess hospital reimbursement rates for inpatient and outpatient services across insurers, payers, and hospitals. This study will also be completed during Cycle I.
- Wakely Consulting Group has completed initial studies on cost drivers, financial data, enrollment trends, interstate comparisons, and benchmarks to support the 2011 rate factor review process.

Enhance the rate review process through staffing:

- Cycle I grant funds were used to hire a Principal Policy Associate, Angela Sherwin, who has managed the activities of the Cycle I grant funds to date.
- Cycle I has also funded a full-time staff member dedicated to managing the rate review process, Maria Casale. Maria has been responsible for creating a database of rate filing information and completing data entry for all filings as of June 2011.
- Funds from Cycle I were transferred to NAIC to assist in developing and implementing revised SERFF modules to capture and report additional information related to rate filings.

Improve consumer protection standards and communications in the rate review process:

- An RFP has been drafted to procure and contract directly with a community organization to assist OHIC in engaging consumers in the rate review process.
- A contract with Wakely Consulting Group was executed in order to help OHIC increase and improve public awareness and accessibility of rate filing submissions and decisions. Additionally, Wakely will assist OHIC in communicating the results of evaluations conducted through this grant to interested stakeholders, including health plans, hospitals, providers, and regulators.

Information Technology and Systems Capacity

Health insurance carriers in Rhode Island file their proposed rate factors using the NAIC System for Electronic Rate and Form Filing (SERFF) and use a standard form to report their projected annual rate of price and utilization increases for a variety of categories, including

hospital inpatient, hospital outpatient, pharmacy, primary care, and all other medical as well as the projected portion of premium for administrative costs and reserves or profits (Attachment 1).

Budget and Staffing

OHIC is annually appropriated and received approximately $547,000 from the state's General Revenue Funds for state fiscal year 2012. This amount is similar to past years. Additionally, OHIC shares full-time equivalents (FTEs) with DBR: 75% of an FTE supports OHIC's work related to consumer protections, such as processing complaints, reviewing policies and other filed forms; and one or more FTEs support financial examinations of health insurers. OHIC uses consulting staff as needed for rate review and special examinations as called by the Commissioner. Additionally, the Principal Policy Associate and Rate Review Manager are fully funded through Rate Review Cycle I grant.

Overall, approximately 25% of OHIC's appropriated budget is spent for rate review, most of which is dedicated to staff time and consulting fees. This commitment from appropriated funds did not change with the receipt of federal funds from Cycle I of the Rate Review Grant. All Cycle I funds were in addition to the state funds previously committed. Actuarial expenses are billed directly to health insurers by state statute.[14] Billings for actuarial services totaled $78,875 in 2010.

The Health Insurance Commissioner, a cabinet level official, has executive authority over the rate factor review. Christopher Koller is currently Commissioner.[15] The Executive Counsel to OHIC, Herb Olsen, an attorney with both industry and regulatory experience, provides legal expertise to the rate factor review process.[16] OHIC contracts with an independent, self-employed, out-of-state actuary for all technical analyses. Since OHIC's inception, they have used DeWeese Consulting, Inc. for virtually all actuarial services.

The Principal Policy Associate, Angela Sherwin, has been a part-time consultant to OHIC since 2008 and became a full-time employee under the Rate Review Cycle I funds in December 2010.[17] As a consultant, she worked on the development of the affordability standards. In her role as Principal Policy Associate, Angela has managed the activities of the Cycle I rate review grant, provided analytic support to the rate review process, and coordinated rate review efforts with health insurance Exchange planning in Rhode Island. Maria Casale was hired as the Rate Review Manager and started work at OHIC in January 2011.[18] Prior to working at OHIC, she has worked on projects that have interpreted and analyzed financial data, fees, and improved process efficiencies. As part of her job as the Rate Review Manager, she oversees OHIC's data submissions in SERFF and works with the actuary to ensure rate data collection accuracy for rate review. She is also responsible for rate data review and subsequent submission of the quarterly HHS analytical data download from SERFF.

OHIC received 121 rate filings in 2010, 45 of which were for Medicare Supplement plans. There were a total of 58 filings reviewed year-to-date (YTD) for 2011, including both Medicare and dental plan filings (not reportable to HHS).

[14] Actuarial fees are billed to insurers per Rhode Island General Law 42-14-10
[15] See attachment 3 for Koller's resume
[16] See attachment 4 for Olson's resume
[17] See attachment 5 for Sherwin's resume
[18] See attachment 6 for Casale's resume

Consumer Protections

All significant rate filings are publicly disclosed and prominently posted on OHIC's website. The state statutes regulating the rate review process require that "any documents presented in support of a filing of proposed rates under this section shall be made available for public examination at any time and place that the director may deem reasonable".[19] OHIC publishes rate factors for administrative costs, profits and surplus, and five medical service categories, as well as the price and inflation factors for each of the medical service categories. OHIC posts all proposed rate factors for oral and written public comment.[20] At the conclusion of each review, the rate decision and any health plan responses are posted to OHIC's website with related press releases.

In addition to posting rate factors and sections of the filing, OHIC also posts associated analyses for consumers to read and examine. This year, OHIC posted seven analyses on the 2012 submitted rate factors (described in the section "Internal Review" above): (1) Cost Driver Analysis, (2) Analysis of Rhode Island Commercial Insurance Administrative Expense Trends 2005-2010, (3) New England Group Health Plan Benchmarking, (4) Health System Improvements Survey, (5) Standards for Rate Factor Review – Health Plan Evaluation, (6) Provider Contracting Survey Summary, and (7) Analysis of Past Performance Relative to Requested and Approved Rate Factors. All significant final rate review decisions are posted in plain language on the OHIC web site and communicated in press releases.

There is no legal minimum notice requirement but carriers typically provide notice of premium changes at least 30 days prior to renewal and rates must stay in effect for 12 months. Public comments on rate filings are usually collected for four weeks.

At OHIC's discretion, rate factors may also be publicly discussed through public meetings and/or formal hearings. Public meetings are opportunities for the commissioner to hear comments from members of the public before making a rate decision (conducted before the Commissioner issues a rate factor decision in small and large group markets).

DBR has documented receipt of 40 complaints this year to date from consumers regarding their health insurance coverage. Both the Department of Health and the Attorney General also receive consumer complaints related to health insurance, but the quantity and nature of these complaints are not shared with OHIC.

Examination and Oversight

There were no formal actions taken against any insurance companies aside from rate factor decisions (approval, modification, or rejection). OHIC reviews and modifies approximately 150 rate filings each year and also conducts market conduct examinations concerning how carriers apply approved. There was only one formal hearing this year: the direct pay hearing for the individual market. Before the hearing in November 2010, BCBSRI originally requested an average rate increase of 8.1% for its Direct Pay market line of products to be

[19] Rhode Island General Laws that govern public disclosure and access to rate filing information include per the Access to Public Record Act (RIGL 38-1-1-et seq.), 27-19-6, 27-20-6, and 42-62-13. AG opinion PR 09-01 (http://www.riag.state.ri.us/civilcriminal/show.php?id=568) also applies.

[20] Review of Health Plan Rate Factors for 2012 Rates: Rate Factor Review Template – User's Guide, May 2011. Available at: http://www.ohic.ri.gov/documents/Insurers/Regulatory%20Actions/2011%20rate%20factor%20documents/2_2012%20Rate%20Factor%20Review%20Template%20&%20Users%20Guide%20updated%205-18.pdf

effective April 1, 2011. However, the Attorney General (AG), on behalf of the state of RI, raised objections to this rate increase due to high trend factors, improper administrative costs, inappropriate contribution to reserves, and the inclusion of tax and assessment costs in contravention of last year's order by the Commissioner. The AG argued that BCBSRI should be allowed an average rate increase of 0.4% rather than 8.1%. At the January hearing, BCBSRI revised its budget and reduced the average rate increase requested to 7.9%. The Hearing officer present at the hearing recommended that the rate increased should be reduced to 0.34% because: (1) BCBSRI failed to provide adequate support in the record for its trend factors, (2) there was inadequate evidence to support accuracy or reasonableness of its budget, (3) BCBSRI was not allowed to include a contribution to its reserves, (4) the recovery of IT costs through a 0.34% increase was reasonable, and (5) BCBSRI should not pass along state assessments and state premium taxes to its Direct Pay customers because it failed to satisfy the conditions imposed by the Commissioner for properly apportioning state assessments. After consideration, the Commissioner lowered BCBSRI's requested rate to an estimated 1.9% instead of the original requested 7.9% by: (1) eliminating the anticipated contribution to reserves, (2) disallowing of costs of premium tax on commercial insurance, (3) disallowing allocation of costs of publicly purchased vaccines, and (4) reducing the trend factors for 3 of 8 medical services category.

Rhode Island has established a comprehensive, transparent rate factor review process that has achieved savings for Rhode Islanders. For example, rate factor decisions made by OHIC in 2008 resulted in $15-20 million in annual savings to large employers.[21] In 2009, insurers voluntarily withdrew their requests for rate increases in the small and large group markets, which effectively froze premium rates for six months. In the individual market, OHIC granted no rate increase in 2009 and rate increases of 8.7% and 7% in 2008 and 2010. A rate increase of 7.9% was requested by BCBSRI for the individual market in 2011, and OHIC approved a rate increase of 1.9%.[22] In 2011, the health plans requested an overall average premium increase of 10.5% (BCBSRI), 18.0% (United), and 4.8% (Tufts) for the small group market. For the large group market, BCBSRI requested a 10.5% overall average premium increase, United requested 20.1%, and Tufts requested 4.8%. A chart summarizing proposed and approved rate factors for 2008 – 2011 can be found in Attachment 7. Rate decisions for 2011 (for rate factors applied to 2012) are pending. The decision will be announced in early August and will be posted on OHIC's website for public access.

B. Proposal to Meet Cycle II Program Requirements

Cycle I grant funds have allowed OHIC to make much progress in increasing the capacity of existing rate review activities, enhancing staffing, and improving consumer standards and communications. OHIC proposes to use funds from this grant to improve its comprehensive rate review to accomplish two primary goals: (1) institutionalize the rate review process and (2) engage health plans in a delivery system transformation. OHIC will share its monitoring and results with Federal Officials as well as make the information readily publicly accessible.

[21] See OHIC Press Release (June 13, 2008):
http://www.ohic.ri.gov/documents/Press/PressReleases/2008BCLargeGroupApproval/1_2008%20large%20group%20rate%20modification%20press%20release.pdf
[22] See OHIC Press Release (March 9, 2011):
http://www.ohic.ri.gov/documents/Press/PressReleases/PR11%20direct%20pay/press%20release%20March%209,%202011.pdf

Measurable objective milestones and the timeline associated with each activity are included in the attached Workplan and Timeline document.

Institutionalizing Rate Review

OHIC will use federal funds from the Cycle II grant to institutionalize Rhode Island's rate review process. This institutionalization will include enhancing staffing dedicated to the rate review process, continuing the consumer engagement begun during Cycle I, documenting the rate review process and procedures, improving filing requirements, and supporting NAIC's SERFF updates.

Enhancing the Rate Review Process: Staffing

Cycle II funds will support two full-time staff members dedicated to institutionalizing rate review in Rhode Island. Cycle I funds were used to hire a full-time rate review manager, Maria Casale, to manage the formal rate filing process and Cycle II grant funds will continue to fully support this position. The rate review manager is responsible for obtaining all filings and posting rate review decisions through SERFF. Additionally, the manager assists the actuary and Executive Counsel to review the nearly 300 filings received by OHIC each year. This manager also coordinates all communication with insurers and stakeholders related to rate review.

OHIC will also fully support an operations manager position. The principal responsibilities and functions of the operations manager lie within four main areas: (1) consumer services, (2) market conduct, (3) health insurance rates, and (4) health insurance forms. Currently these functions are either not being performed, or done partially by OHIC Counsel – as a consequence of which other legal matters are left unattended.

Consumer services: The operations manager will coordinate activities and revisions with other agencies with consumer services responsibilities (the Department of Business Regulation; the Department of Health; and the Attorney General's Office), develop and implement an efficient data collection process, and in coordination with other agencies, develop a written and web-based consumer guide to Rhode Island health insurance consumer services.

Market Conduct: The operations manager will develop and implement an effective process to collect market conduct data from carriers, prepare for approval by the Commissioner and Legal Counsel a proposed annual market conduct plan, make recommendations to the Commissioner and Legal Counsel for specific examinations, and retain and provide regular oversight of examiners and ensure that examinations are completed in a timely manner.

Health Insurance Rates: The operations manager will review pending rate requests with the Office's actuary, and with the Commissioner and Legal Counsel as necessary, and approve or disapprove requests and assist with and support the annual small and large group rate factor review.

Health Insurance Forms: The operations manager will develop a proposed checklist or set of criteria for approval or disapproval of policy forms and certificates of coverage that includes statutory benefit requirements, federal health insurance requirements,

Department of Health utilization review and quality assurance requirements, and standards relating to frequently occurring issues (e.g. discretionary clauses; arbitration; liquidated damages).

Consumer Engagement

Funds from the Cycle I rate review grant are supporting a community organization that promotes purchaser and consumer engagement in the rate review process. This organization is charged with raising awareness and knowledge of both the rate factor review process and the underlying cost drivers of health insurance premium increases with purchasers and the public by collecting public comment and generating additional analyses relative to consumer engagement. Cycle II grant funds will continue funding for community organizations selected during Cycle I to engage consumer and purchasers in the implementation of affordability standards and in dialogue about the future of commercial health insurance in Rhode Island. Ongoing partnership with a community organization will further OHIC's mission of transparency, public disclosure, and education of the public on health insurance cost drivers and the strengths and limitations of health insurance rate review.

Documentation and Institutionalization of Rate Review Process and Procedures

OHIC will dedicate a portion of the Cycle II grant funds to the rate review documentation project. Much of the rate factor review process described in this application has not been committed to regulation nor policies and procedures, rendering it vulnerable to personnel turnover. OHIC will contract with a legal expert to draft an operations manual for the rate review process. This manual will document historical rate review activities and decisions as well as the current process and procedure for rate review. The documentation effort will culminate in the promulgation of a policy and procedure manual and regulation to institutionalize rate review processes and procedures. The Operations Manager will oversee this project.

Improving Filing Requirements

OHIC's actuary and the Director of Financial Examinations of the Insurance Division of the Department of Business Regulation will collaborate on the development of revisions to the Health Insurance Supplemental Annual Statement. The goals of this project are to collect data from carriers on a regular basis concerning enrollment in insured and self-insured plans, make the collection of rate component data consistent across carriers, and reconcile financial data collected in the standard Annual Statement with data collected in the Health Insurance Supplement.

Enhancing the Rate Review Process - IT Capacity

OHIC will allocate money from the Cycle II grant to assist NAIC's proposal to improve SERFF. Enhancements to the SERFF system will:

- **Data Collection from Industry:** The SERFF system will be enhanced to assist with collection of all parts of the industry Preliminary Justification for rate increases. Part I, the Rate Increase Summary Worksheet, will be collected as an attachment to a Submission Requirement. The SERFF system will parse this attachment into database fields to allow for search and export capabilities. Part II, the Written Explanation of Rate Increase, will also be collected with the filing submission—which is Part III,

Rate Filing Documentation. Finally, a Submission Requirement will be added to collect the Consumer Disclosure form. Companies will be expected to retrieve the Consumer Disclosure Form from the Health Insurance Oversight System (HIOS) and upload it to SERFF.

- **State Data Input:** SERFF will be modified to allow the states to enter a Summary of Rate Review and/or a State Filing Summary. The state will be able to submit the Summary of Rate Review to HHS via SERFF following the review process.
- **Enhancements to Health Filing Access Interface (HFAI):** The HFAI will be enhanced to allow states to display the information above and to accept and process public comments on rate filings. States will have the option to make the Rate Increase Summary Worksheet, the Consumer Disclosure Form, the State Filing Summary, and the Summary of Rate Review available to the public as part of the HFAI system or via SERFF's existing public access. States may choose if and when these pieces are made public, using their existing guidelines for public access. Additionally, HFAI and SERFF will be enhanced to support the collection of public comments via HFAI and to provide states an interface to manage the collection and posting of those comments from SERFF

Implementing Affordability Standards

As a nationally acknowledged leader in health insurance rate review, Rhode Island has learned that an effective rate review process alone will not improve the affordability of health insurance without addressing the underlying costs of medical care and growing medical trend. OHIC holds insurers accountable for working towards affordability of coverage through enforcing the Affordability Standards (articulated in Section A) through the rate review process. Activities under this second Cycle II goal include enhancing the rate review process through developing analytic capacity and continued support for implementing affordability standards.

Enhancing Rate Review Process – Developing Analytic Capacity

OHIC will use Cycle II funds to support updated hospital utilization and hospital payment studies conducted with Cycle I funds. Both of these studies allow OHIC to evaluate and support the Affordability Standards. The hospital utilization will allow OHIC and the RI Department of Health (HEALTH) to assess trends in avoiding emergency room utilization, preventable hospitalizations, and readmissions as compared to the baseline trends established through the study conducted with Cycle I funds. The Hospital Payment Study will allow OHIC to conduct a second analysis of inpatient and outpatient price trends by carrier. Payments and costs will be evaluated by payer type (commercial, Medicare, and Medicaid) to document any cross-subsidization among payers that may contribute to rising commercial health insurance costs. The analysis conducted with Cycle II funds will be compared to the hospital payment analysis conducted with Cycle I funds to identify any changes over time and any opportunities for broader delivery system reform. In OHIC's experience, rate review must be connected to a comprehensive delivery system analysis, such as these two studies, in order to ensure affordable health insurance.

In Rhode Island, the Department of Health is currently implementing an all-payer claims database (APCD), which will collect accurate health care utilization and payment information from public and private third-party payers in a transparent manner. Once this database is fully implemented, the database will substantially support OHIC's evaluation of commercial health insurer rate factor filings. The APCD will provide data for ongoing hospital utilization and payment studies described above to determine relative payments and trends across insurers to document any continued cost shift between public and private payers. Additionally, OHIC will be able to verify price and utilization trends proposed in the rate factor review with actual history collected in the APCD. OHIC will also have a consistent data source for regular studies of the metrics for affordability standards, documenting changes over time in emergency visits for ambulatory care sensitive conditions, preventable hospitalizations, and re-admissions. Prior to establishing the APCD, all of these studies required data requests to each commercial and public insurer, and time-intensive data cleaning and preparing for each study. In order to ensure the business needs of rate review are adequately considered as the APCD is implemented, OHIC will support the development of an analytic and reporting plan specific to rate review from the APCD. As the database is updated quarterly, an analytic vendor will produce a standard set of tables and reports which will "roll up" data which will be needed for rate review, as detailed above. Examples include reporting, benchmarking and trending affordability measures (above), hospital utilization and payment data, primary care utilization, payment and expenditures, and other data reports as needed. The analytic vendor will produce topic-specific policy reports on an annual basis. These reports will be used by the rate review team to inform advisory committees, health plans, and the public about issues such as components and drivers of costs trends, affordability measure trends, hospital and physician utilization and payment trends, etc. This will provide the information underpinnings for rate review discussion and justification for rate review decisions.

Additionally, OHIC will also partially support efforts to develop a public portal for direct consumer access to the APCD information. The web-based portal will provide users with the ability to easily do basic queries and analytics without having to house a database extract themselves. This easy access will be extremely useful to the OHIC staff supporting the rate review function.

Enhancing the Rate Review Process – Staffing

In order to improve the rate review process and engage health plans in delivery system transformation, Cycle II grant funding will be used to support a full-time Affordability Standards Associate who will monitor the affordability standards, work with providers to measure benchmarks of affordability, work with health insurance carriers on benefit design, and work with providers on reporting and analysis to document trends in affordability over time. The Affordability Standards Associate will oversee both the hospital utilization and the hospital payment studies during Cycle II of the rate review grant.

Additionally, a strategic analyst will be hired and will assist the Affordability Standards Associate. The strategic analyst must have quantitative analysis skills (actuarial skills preferred). The strategic analyst will perform analyses of outputs from the APCD and complete ad hoc data and reporting pertaining to the rate review process for OHIC, as needed. This analyst will be funded in part by Rate Review Cycle II and in part by Exchange Establishment Two funds. The

analyst will not replace the work of the consulting actuary OHIC uses for rate review, but permit more intensive analysis of medical care utilization trends.

Implementing Affordability Standards – All-Payer Medical Home Expansion

OHIC will enhance insurer compliance with the affordability standard that requires commercial insurers to participate in the all-payer medical home effort in Rhode Island. OHIC established the Chronic Care Sustainability Initiative (CSI) six years ago to promote payment reform to primary care. While successful as a nationally recognized pilot project (Medicare has selected RI as one of eight sites for participation in local all payer patient-centered medical home projects) the CSI project has remained a small, voluntary effort with limited impact. Federal funding from the Cycle II rate review grant will be used to support implementation of all-payer medical home legislation which was passed this year and made insurer participation a requirement, not merely voluntary effort. Additionally, funding from the Cycle II grant will support the spread of medical home best practices developed in 13 pilot sites of the Chronic Care Sustainability Initiative to the rest of primary care community through the promulgation of contractual standards used by insurers. Funding will also be used to communicate results of the APCD analysis to doctors so they can improve their practices. Finally, grant funds will support staff to work with stakeholders and purchasers to change benefit designs to support more primary care use. OHIC's rate factor review process will monitor the project's efficacy by continuing to place emphasis and public attention on the medical expense trends and price and utilization factors predicted by insurance carriers in their submissions – trends which the PCMH project should mitigate.

Cycle II activities supporting both goals

Cycle II funds will be used to support a grants financial officer whose rate review related scope of work will include managing all federal grant money related to rate review (35% of salary and fringe will be funded through Cycle II, the remainder funded through Exchange Establishment funds). This work includes acting as the Authorized Organization Representative for all federal grant applications, coordinating all draw-downs of federal monies, monitoring all contractual requirements and administrative deadlines related to grants, coordinating filing of required fiscal, administrative and programmatic reports with federal agencies, responding to Federal documentation requests, and maintaining organized files to document all grant-related transactions with both federal agencies and RI Department of Administration. Additionally, the grants financial officer will supervise all of the procurement and contracting needs, as it pertains to the Cycle II rate review activities. This position will also be funded through Exchange Establishment Level One and Level Two.

Funds from Cycle II will also be used to increase and improve communications and messaging to the public regarding rate review and the affordability standards. Communications and messaging will also be specific to the impact of commercial market reforms on rate increases. Currently. OHIC's web site is visited 500 times a week on average. OHIC's information and analyses regarding cost drivers and its affordability standards are not as widely disseminated and used as they could be for the purposes of stakeholder education. Cycle II funds will provide for a communications consultant tasked specifically to increase public awareness of OHIC's rate factor reviews, analyses and results. Together with the community partner funded

under Cycle II, this will result in greater consumer awareness of and engagement in the rate factor review process.

C. Reporting to the Secretary

The OHIC attests that it will comply with the reporting requirements outlined in statute and in the grant solicitation. The Rate Review Manager will collect and provide data to the Secretary on the timeline requested by HHS. OHIC will transmit the data using the uniform reporting template to be provided by HHS to grant awardees.

We have provided trend data as requested from 2008 through 2011 in Attachment 7.

D. Recommendations to the State Exchange on Insurer Participation

Rhode Island will commit to making recommendations, as appropriate, to its State Exchange about whether particular health insurers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified rate increases. OHIC will continue to work closely with those implementing the Exchange in Rhode Island to determine the best practices and procedures for making recommendations as needed. OHIC commits to providing updates in quarterly reports to HHS about our collaboration with the Exchange.

E. Optional Data Center Funding

Rhode Island will not use grant funds to establish an optional Data Center.

F. Commitment to Mentor States

The previously described rate review process indicates that Rhode Island is a national leader in premium review and meets the proposed effective rate review requirements as dictated by the U.S. Department of Health and Human Services. OHIC reviews proposed rates for individual, small, and large group markets annually. Rhode Island will mentor States that are in the process of developing an effective rate review program. We are willing to share our work and offer any insight or advice that other States would find helpful as they establish and execute their own processes.

G. Evaluation Plan

Rhode Island's application for the Rate Review Cycle II grant funds is focused on:

(1) Institutionalizing the rate review process; and

(2) Engaging the health plans in delivery system transformation through implementation of OHIC's Affordability Standards.

Our Cycle II evaluation plan is designed to monitor progress and measure the success of our efforts not only within these two specific areas, but also for the overall goals of the rate review process. This evaluation plan will ensure that the Cycle II deliverables are met, on time and on

budget, and that sufficient organizational structure, work plans, processes and reporting tools are present to identify and escalate issues as needed.

Specifically, the evaluation plan presented in this application includes the following:

(1) Discussion of chosen key indicators to be measured;

(2) Description of baseline data for each indicator;

(3) Methods to monitor progress and evaluate the achievement of program goals both on an ongoing basis and at the conclusion of the program; and

(4) Inclusion of plans for timely interventions when targets are not met or obstacles delay progress.

Key Indicators to be Measured

The work plan and timeline identifies the principle tasks and milestones to be completed and achieved within each area during the Cycle II funding period. These tasks and milestones are the project's key indicators to be measured. We will monitor progress toward task completion and milestones achievement on an ongoing basis with regular management reports, providing input to the Quarterly Reports provided to HHS.

Baseline Data for Each Indicator

The template below presents the framework to be used in documenting applicable baseline data for each key project task and milestone. These data will provide the starting point from which project progress for each milestone will be measured, through the reports discussed below. These baseline data will be compiled at the initiation of the Cycle II funding period.

Indicator	Project Lead	Baseline

Methods and their Efficacy to Monitor Progress and Evaluate the Achievement of Program Goals

Project task and milestone progress is currently monitored by management, discussed in weekly team meetings and documented in Monthly Progress Reports, as well as Quarterly Reports to HHS. OHIC staff, including the Affordability Standards Associate and the Operations Manager, will compile these reports. They will solicit input from the project staff, consultants, and other Rhode Island State agencies responsible for specific tasks and milestones.

The evaluation process will include the following four elements:

(1) Project Status Reports

Project status reports will be formalized, focusing in greater detail on which key tasks and milestones have been completed on schedule, those running behind schedule, and the mitigation strategy for those likely to miss the original scheduled completion date. For each key task and milestone likely to be late, a mitigation strategy will be identified, defining specific actions to be taken to assure completion in a timeframe that does not compromise other tasks and milestones. The project leads will be responsible for overseeing task completion and mitigation strategy implementation for their respective projects.

(2) Deliverables Review

A detailed deliverables review process shall be implemented in order to assure the timeliness, accuracy, and completeness of project deliverables. The project team is committed to producing and receiving high-quality deliverables from both internal and external sources. We will follow a proven approach to deliverables development, focused on defect prevention, and ongoing quality improvement, taking into account the premium placed on the time and resources of project staff, as well as that of other stakeholders and consultants. Core deliverables will be placed into our online project repository and all authorized parties will be sent an –email and link to the item, which they can then access, view, or download as desired. The deliverables' content, schedule, presentation, tracking, and approval process will be agreed to in advance and documented in the communications plan. Project staff, stakeholders and consultants will agree on the specific content, format, and acceptance criteria for all deliverables as well as the timelines and due dates for deliverables' review and completion.

(3) Communications among Project Staff and Stakeholders

An effective communications plan, both to support internal and external communications is a key component of the project team's overall management approach and method to assure effective progress monitoring and achievement of program goals. For external communications, we have established a structured stakeholder effort through the HIAC. For internal communications among project management staff, we will set up a project portal, to serve as the primary entry point for Web browser access to various communications documents, as well as deliverable documentation.

(4) Timely Interventions when Targets are not Met or Unexpected Obstacles Delay Plans

Rhode Island's Project Director will lead the project's efforts in monitoring task and milestone progress, in addition to meeting the project's overall goals. The principal tools for monitoring project performance will be the progress reports noted above coupled with ongoing frequent communication with not only project staff but also stakeholders and consultants. The most effective risk management strategy is risk avoidance. Consequently, our management team asks the following key questions of all parties responsible for project activities and tasks on an ongoing basis:

(1) Is the task scope being managed effectively?

(2) Are timelines accurate? Are we meeting our schedule?

(3) Are deliverables completed consistent with quality standards?

(4) Are risks and issues managed appropriately?

(5) Are the review processes effective?

(6) Are we working efficiently?

(7) Is the project meeting all contractual requirements?

(8) Are stakeholders, including HHS satisfied?

This frequent ongoing communication enables us to identify the need for interventions in a timely manner when they may not be met or unexpected circumstances may cause delay in task completion or milestone achievement. We will track issue metrics and monitor, on an ongoing basis, the issues opened, closed, and pending each month and their relative priority and severity.

The template below provides a Sample Issues Management List as an example of the type of tracking sheet we will use to monitor issues, as well as the status of key tasks and milestones - both completed and outstanding.

Project Lead	**Task – Milestone – Deliverable**	**Due Date**	**Revised Due Date**	**Problem**	**Mitigation**	**Status** (Complete, On-Schedule, Late, Seriously Late)

Plan for Ongoing Evaluation of Rate Review Activities

In addition to process measures, OHIC will evaluate the success of rate review activities through the results of reports and analyses proposed to be funded through Cycle II of the Rate Review grant. Specifically, OHIC will track premium trend rates over time, hospital payment rates, and hospital utilization as metrics of affordability.